



**PIPEFITTERS LOCAL 636**  
**FRINGE BENEFIT FUNDS**  
P.O. BOX 278  
TROY, MICHIGAN 48099-0278  
(248) 641-4936 (888) 646-8920

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**OPT-OUT BENEFITS ENROLLMENT FORM**

You must execute this form to receive Opt-Out benefits, instead of comprehensive medical and prescription drug benefits, from the Fund. Opt-Out benefits include (1) supplemental short-term disability for Active Employees, and (2) a self-funded prescription drug benefit, vision and dental benefits, and an enhanced health reimbursement account for Active Employees and Pensioners. If you enroll for Opt-Out benefits, your Dependents will also be enrolled in Opt-Out benefits. Once the Opt-Out option is selected, you will be allowed to re-enroll in comprehensive medical and prescription drug coverage only upon the earlier of:

- The next January Open Enrollment, or
- The first of the month following the month in which you notify the Fund that your other coverage terminated, or you have a new dependent as a result of marriage, birth, adoption or placement for adoption, **but only if you provided the Fund notice within 30 days of such an event.**

If you desire to enroll in Opt-Out benefits, please complete the following:

\_\_\_\_\_  
Name- Last      First      M.I.      Date of Birth      Social Security No.

**Beneficiary Designation:**  
**Primary**

\_\_\_\_\_  
Name- Last      First      M.I.      Relationship      Date of Birth

**Secondary**

\_\_\_\_\_  
Name- Last      First      M.I.      Relationship      Date of Birth

**Statement of Health Coverage:**

I have attached proof that I have comprehensive medical and prescription drug coverage under another group health plan or health insurance.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date